

BioAgilytix

Diagnostics

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Please Complete All Fields

Client Information		Patient Information	
Client Name:		Patient Name:	
Street Address:		Patient ID:	
City, State, Zip:		Date of Birth:	
Phone/Fax:		Gender:	
Sample Information			
Collection Date:		Time Collected:	

Available Tests					
Select	Test Name	*Matrix, Tube	Select	Test Name	*Matrix, Tube
<input type="checkbox"/>	Adenosine Deaminase	S, RT	<input type="checkbox"/>	Echovirus Neutralization Assay - CSF	CSF
<input type="checkbox"/>	Anti-Phosphatidyl Panel I (Gly, Inos, IgG, IgM, IgA)	S, RT	<input type="checkbox"/>	Echovirus Neutralization Assay - Serum	S, RT
<input type="checkbox"/>	Anti-Phosphatidyl Panel II (Acid, Eth, Gly, Inos, IgG, IgM, IgA)	S, RT	<input type="checkbox"/>	Endomysial IgG Antibody Titer	S, RT
<input type="checkbox"/>	Anti-Phosphatidyl Panel III (Acid, Chol, Eth, Gly, Inos, IgG, IgM, IgA)	S, RT	<input type="checkbox"/>	Francisella tularensis IgG, IgM	S, RT
<input type="checkbox"/>	Anti-Phosphatidic Acid IgG, IgM, IgA	S, RT	<input type="checkbox"/>	Giardia IgG, IgM, IgA	S, RT
<input type="checkbox"/>	Anti-Phosphatidyl Choline IgG, IgM, IgA	S, RT	<input type="checkbox"/>	Glutathione, Total NYS	WB, YT, RF
<input type="checkbox"/>	Anti-Phosphatidyl Ethanolamine IgG, IgM, IgA NYS	S, RT	<input type="checkbox"/>	Glycosaminoglycans (GAGs) NYS	U
<input type="checkbox"/>	Anti-Phosphatidyl Glycerol IgG, IgM, IgA	S, RT	<input type="checkbox"/>	Hepatitis D Antigen NYS	S, RT
<input type="checkbox"/>	Anti-Phosphatidyl Inositol IgG, IgM, IgA	S, RT	<input type="checkbox"/>	HIV-2 RNA Detection - Plasma	P, LT
<input type="checkbox"/>	Arbovirus IgG / IgM Panel NYS	S, RT	<input type="checkbox"/>	HIV-2 RNA Detection - Serum	S, RT
<input type="checkbox"/>	Arbovirus IgG Panel NYS	S, RT	<input type="checkbox"/>	Human Placental Lactogen	S, RT
<input type="checkbox"/>	Arbovirus IgM Panel NYS	S, RT	<input type="checkbox"/>	ImmunoProfile Antibody Test System™ NYS	DBS, K
<input type="checkbox"/>	Arbovirus IgG / IgM Panel w/ West Nile	CSF	<input type="checkbox"/>	Leptospira IgM NYS	S, RT
<input type="checkbox"/>	Arbovirus IgG Panel w/ West Nile	CSF	<input type="checkbox"/>	Mycoplasma pneumoniae IgA	S, RT
<input type="checkbox"/>	Arbovirus IgM Panel w/ West Nile	CSF	<input type="checkbox"/>	Pancreastatin NYS Conditional	S, RT
<input type="checkbox"/>	Borrelia burgdorferi IgG & IgM - CSF	CSF	<input type="checkbox"/>	Porphyryns Total Plasma	P, GT - LP
<input type="checkbox"/>	Borrelia burgdorferi IgG & IgM - Plasma	P, GT	<input type="checkbox"/>	Porphyryns Total Serum	S, RT - LP
<input type="checkbox"/>	Borrelia burgdorferi IgG & IgM - Serum NYS	S, RT	<input type="checkbox"/>	Porphyryns, Fractionation	P, GT - LP
<input type="checkbox"/>	Borrelia burgdorferi IgG - Plasma	P, GT	<input type="checkbox"/>	Q Fever IgG NYS	S, RT
<input type="checkbox"/>	Borrelia burgdorferi IgG - Serum NYS	S, RT	<input type="checkbox"/>	Q Fever IgM NYS	S, RT
<input type="checkbox"/>	Borrelia burgdorferi IgM - Plasma	P, GT	<input type="checkbox"/>	Q Fever IgG & IgM Panel (Phase I, II) NYS	S, RT
<input type="checkbox"/>	Borrelia burgdorferi IgM - Serum NYS	S, RT	<input type="checkbox"/>	Schistosoma IgG NYS	S, RT
<input type="checkbox"/>	Candida Immune Complex	S, RT	<input type="checkbox"/>	Substance P	S, RT
<input type="checkbox"/>	Chlamydia trachomatis IgG, IgM, IgA	S, RT	<input type="checkbox"/>	Transforming Growth Factor β 1 NYS	P, LT
<input type="checkbox"/>	Chlamydia Expanded IgG, IgM, IgA (trach, pneu, psi)	S, RT	<input type="checkbox"/>	Transglutaminase IgG, IgM, IgA NYS	S, RT
<input type="checkbox"/>	D-Lactate	P, GyT	<input type="checkbox"/>	Vitamin B ₅ (Pantothenic Acid)	S, RT
<input type="checkbox"/>	Disaccharidases	T	<input type="checkbox"/>	Vitamin B ₇ (Biotin) NYS	S, RT - LP

*Matrix: S = Serum, P = Plasma, WB = Whole Blood, T = Tissue, U = Urine, CSF = Cerebrospinal Fluid (Sterile), DBS = Dried Blood Spot

*Tube: YT = Yellow Top, LT = Lavender Top, GT = Green Top, RT = Red Top / SST, GyT = Gray Top, K = Kit Provided By ImmunoProfile

*Condition: LP = Light Protected, RF = Must Be Shipped Refrigerated

NYS = DENOTES NEW YORK STATE APPROVAL

ALL SPECIMENS (EXCEPT GLUTATHIONE AND IMMUNOPROFILE) SHOULD BE SHIPPED FROZEN ON DRY ICE

Physician Signature: _____ NPI: _____ Date: _____

Signature required if sending from physician's office

License Numbers:

CLIA: 22D0926993 CAP: 7191028 FDA: 3003006583 MA: 5039 CA: CDS 00800101 MD: 938 NY: PFI 7366 PA: 26731A RI: LCO00559

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